NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA – Department of Health and Human Services
Division of Public Health – Licensure Unit
P.O. Box 94986, Lincoln, NE 68509-4986

Check one:
☐ Renew License
☐ Change of Location
☐ Change of Ownership

Nursing Home Licensure Renewal Application

Expiration Date: _____

Nursing Home Type *(Please Check One)*:
☐ Skilled Nursing Facility ☐ Nursing Facility ☐ Intermediate Care Facility

Renewal Licensure Fees:

1 – 50 beds	$1,550
51 – 100 beds	$1,750
101 or more	$1,950

Make payment to DHHS

This form may be filled out online and mailed to DHHS Licensure Unit at the address listed above.

IDENTIFYING INFORMATION

1. NAME AND ADDRESS OF FACILITY:

_____
_____
_____
_____

2. PREFERRED MAILING ADDRESS (IF DIFFERENT FROM FACILITY ADDRESS) FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT

_____
_____
_____
_____

LICENSE NUMBER: _____
TELEPHONE NUMBER: _____
FAX NUMBER: _____
ADMINISTRATOR: _____
DIRECTOR OF NURSING: _____
EMAIL ADDRESS: _____

3. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: _____

4. NUMBER OF BEDS TO BE RELICENSED: _____

5. ACCREDITATION/CERTIFICATION *(Check If Applicable)*: ☐ JCAHO ☐ Medicare ☐ Medicaid ☐ Other: _____
Are you requesting deemed status? ☐ Yes ☐ No

6. SPECIAL CARE AND TREATMENT SPECIFICALLY FOR THE FOLLOWING GROUPS *(Please Check)*:
☐ Physical Therapy ☐ Alzheimer's/Special Care Unit ☐ Speech Therapy
☐ Pediatric ☐ Respiratory ☐ Occupational Therapy
☐ Behavioral Needs ☐ Other *(Please Specify)*: _____

OWNERSHIP INFORMATION

7. OWNERSHIP OF FACILITY: _____
(Legal Name of Corporation, Partnership, Etc.)

MAILING ADDRESS OF OWNERSHIP: _____
_____

8. BUSINESS ORGANIZATION *(Check One)*:
☐ Sole Proprietorship
☐ Partnership
☐ Limited Partnership
☐ Corporation
☐ Limited Liability Company
☐ Government (*If Government, Please Select One)*: ☐ State ☐ District ☐ County ☐ City or Municipal
☐ Other *(Please Specify)*: _____

(Check One)
☐ Profit ☐ Non Profit

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached documents are true and correct and I/we hereby apply for a license.

PLEASE NOTE: Neb. Rev. Stat. Section 71-433 requires: Applications shall be signed by

1. **The owner, if the applicant is an individual or partnership,**
2. **Two of its members, if the applicant is a limited liability company,**
3. **Two of its officers, if the applicant is a corporation, or**
4. **The head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.**

AUTHORIZED REPRESENTATIVE - SIGNATURE	AUTHORIZED REPRESENTATIVE – PRINTED NAME	DATE
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